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ABSTRACT

The mother's reaction to the disclosure of sexual abuse is often dramatic and her particular type of response in turn affects the daughter's coping mechanisms to deal with the abuse and the disclosure. The type of symptoms developed are thus considered in part dependent on the mother's reaction. Mothers of children who have been sexually abused often have intense dependency needs. These mothers frequently look to fulfill these needs through their daughters, consequently, mother and daughter are often involved in a symbiotic, mutually dependent relationship where the daughter is experienced as an extension of her mother's self. Because of this lack of self-other differentiation, these mothers may react to their daughter's disclosure of sexual abuse as an injury to their sense of self and may overlook their child's own needs. Given the premise that mothers and daughters of sexual abuse often exhibit a narcissistic fusion in their pattern of relating, it is the therapeutic task to help the child and the mother to separate and ultimately for the mother to be able to empathize with the child in order to provide selfobject functions for the child. The therapist needs to work with the dyad in the articulation and integration of both the mother's and the child's affectivity in order for the child to ultimately regain and/or develop trust in this and other relationships. (ABL)

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When Daughter's Sexual Abuse is an Injury to Mother's Narcissism

by

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A child's disclosure of sexual abuse shatters a mother's world. The mother's reaction to the disclosure is often dramatic and her particular type of response in turn affects the daughter's coping mechanisms to deal with the abuse and the disclosure. The type of symptoms developed are thus considered in part dependent on the mother's reaction. Clinical material will be presented to support this position. However, it is of utmost importance to keep in mind that the nature of the mother-daughter interaction and the etiology of the child's symptomatology are very complex and only a very small area will be focused upon. It must be also pointed out that in stressing the significance of the mother in the emotional life of the daughter who has experienced sexual abuse, one needs to be cautious not to blame the mother. The significance of the mother's role comes from the central position that she holds in the family with regard to the affective realm of the child's personality development (Liebm & Jacobs, 1990). Treatment recommendations will follow based on the crucial dynamics of mother-daughter relationship.

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Mothers of children who have been sexually abused often have intense dependency needs, having themselves experienced emotional deprivation and abuse during childhood (Kaufman, 1954; Koch & Javis, 1987; Lustig, 1966). These mothers frequently look to

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fulfill these needs through their daughters; consequently, mother and daughter are often involved in a symbiotic, mutually dependent relationship where the daughter is experienced as an extension of her mother's self. It is the premise of this paper that because of this lack of self-other differentiation, these mothers may react to their daughter's disclosure of sexual abuse as an injury to their sense of self and may overlook their child's own needs. The mother's particular reaction may depend on the particular psychological need she expects her daughter to fulfill.

Some of the self psychology concepts may add to the understanding of how this process occurs. Kohut (1977) describes the self as an active agent, "a center of initiative and a recipient of impressions" (1977, p.99). At first this self is without structure, cohesion, or sense of continuity. It relies on the mother to provide those functions. Those functions are called selfobject functions to the extent that from the infant's perspective, self and mother cannot be separated. Through empathic responsiveness to the infant's needs, the parent provides the experience necessary for the gradual development of a resilient self with a full range of affective states, a sense of continuity and cohesion. This occurs by means of an on-going series of mirroring and idealization interexchanges leading to a slow internalization of those selfobject functions. This process, which Kohut called "transmutting internalization" leads to the development of a permanent psychic structure which is the

self. Socarides and Stolorow (1986) have identified areas of the self development. These include the ability to differentiate among different affects, synthesis of mixed feelings, development of affect tolerance, the capacity to use affect as signals to oneself, and the ability to identify and verbalize one's affect states. These integrating selfobject functions are to occur in the mother-child interactions.

Pathology occurs when there is chronic failure in empathy, attributed to deficits in the parent's self development which in turn undermines the healthy development of the child's self. Miller (1981) believes that infants of narcissitically intact mothers will look at their mother's face and find a reflection of themselves in her. Infants of narcissistically deprived mothers will look at their mother's face, will not find a mirror for their own affective states but will meet with their mother's expectations, fears, and plans. The infant then develops something the mother needs at the expense of his or her own self-development because the infant needs his or her mother to survive. Socarides and Stolorow (1986) believe that "an absence of steady, attuned responsiveness to the child's affective states creates minute but significant derailments of optimal affect integration and leads to a propensity to dissociate or disvow affective reactions..." (p. 45), thus making the child vulnerable to self-fragmentation.

Kohut (1971) has identified the narcissistic mother's empathic responses to their children as being unpredictable and

unreliable. They can take either the form of faulty empathy in which the mother overempathizes with those needs and moods of the child that match her own narcissistic states or lack of empathy which involves unresponsiveness to those needs and moods of the child that are not in tune with her own. Similarly, Olden (1958) believes that the narcissistic mother overidentifies with her child to the extent that she assumes that their needs are identical.

This lack of self-other differentiation is more extreme in sexually abusive families as they are generally considered to be enmeshed (Burkett, 1991). The internal boundaries are poor. Parents may be childlike in their dependence and children are often used to meet their parents' needs, whether sexual or emotional. This is described by Burkett (1991) as "the intergenerational transmission of the enmeshed role reversal of the sexually abusive system" (p. 422). Burkett found these mothers to be more self-focused rather than child-focused.

Given this role reversal, two clinical cases of young sexually abused girls will be presented to illustrate how their mothers reacted differently to the disclosure as a function of their own psychological needs. In both cases, mothers were involved in a highly dependent, symbiotic relationship with their daughters. As it is the premise of this paper, the type of symptoms that the girls developed were partially dependent on their mother's reaction to the disclosure, reflecting a wish to fulfill their mother's needs. It is important to note though

that the determining variables of symptomatology are multiple and complex and not all will be addressed in this paper. Some of those variables, noted in the literature, are age of the child, the age difference between the offender and the child, his relationship to the child, nature of the abuse, use of force, and frequency of events (Adams-Tucker, 1982; Courtois,1979; Finklehor, 1979; Tsai et al., 1979).

The literature is controversial about the type of symptoms these girls develop, with some studies (Powell & Chalkley, 1981) actually claiming that some youngsters remain asymptomatic, either at the time of the abuse or later in life. Most studies point to a variety of symptoms such as regressive behavior, poor relationships with peers, school difficulties (Dixon et al., 1978; Lewis et al., 1969), an abnormal interest in sexual play (Krieger et al., 1980), irrational fears, somatic complaints, social withdrawal, and depression (Brown, 1979; McVicar, 1979). Pelletier & Handy (1986) say that the variation in the psychological outcome of child sexual abuse can be explained by the fact that some aspects of the situation are more instrumental in determining the final impact. The rage and hostility felt by the child may be expressed in an internalized manner in the form of depression, fearfulness, anxiety, or psychosomatic symptoms or in an externalized manner such as aggression, learning and behavioral problems associated with distractibility and hyperarousal (Porter et al., 1982; Wolfe & Wolfe, 1988).

Case Histories

Born to a moderately successful and respected African-American family, Vickie's mother was the only child not to achieve according to her family's expectations, i.e., she did poorly academically, worked intermittently at mediocre jobs, and had Vickie out of wedlock. Vickie's mother often acknowledged a sense of having failed to meet her family's standards. It is possible that this mother suffered from a narcissistic disturbance as she was not accepted for whom she was, perhaps with a different set of needs unrecognized and unnurtured by her family. Thus, selfobject functions with her own mother could have been of a disruptive nature.

Vickie was sexually abused by her live-in maternal uncle, at age four. She did not tell her mother who found out because Vickie developed gonorrhea. Following the disclosure, Vickie's mother reacted with rage towards her family who failed to support her, moved to a state far away and completely cut ties. Mother blamed Vickie for her inability to stop the incident. Intellectualy, she was able to recognize how irrational this was but emotionally she could not tolerate the narcissitic injury. She may have previously identified with Vickie as her idealized self, the perfect little girl who would repair all of her injuries. Mother's rage at Vickie may indicate that her defensive narcissistic idealization of her daughter was no longer tenable, and she was faced with the realization of her own sense of damaged self. Because mother could not extricate herself from

her symbiotic ties, she could not be supportive and understanding of Vickie's feelings. The specific traumatic event could have served as a crystallization point for a more general disturbance in the mother-child relationship.

The lack of empathy could be partially related to the symptomatic picture Vickie developed. At age 10, mother brought Vickie for treatment because of excessive clingness to mother and difficulty relating to other children, always needing to prove that she was better than them. Vickie appeared anxious and depressed, was a pseudocompliant "nice girl", and exhibited low self-esteem. She was sexually repressed and showed despise for boys. Mother was actually concerned about her becoming gay. Vickie never talked about the sexual abuse with her mother. It became a taboo. When it was brought up in therapy, it was met with much resistance and anxiety. In her therapeutic interactions, her concerns were mostly of a narcissistic nature, evolving around issues of competition and being good enough, using this therapist as a mirroring object and a source of idealization. She constantly pulled for validation of her self as a worthy, good enough person. However, she had much difficulty trusting this therapist and using her as a reparative selfobject function. She avoided any kind of verbalization of her affective experiences, always protecting her idealized image of her mother and failing to own up to her disowned anger at her mother's blaming, feelings of disappointment, and her mother's inability to help her heal her own injuries. It seems that

Vickie internalized her anger in order to preserve her symbiotic tie with her mother.

Grace is a 7-year-old Hispanic girl who was brought to treatment because she alledged that her father had sexually molested her. Parents were never married and Grace visited her father and his wife at times on weekends. The details of the alledged abuse were very unclear. Contrary to Vickie's mother, not only did Grace's mother believe and support her but used all the resources available to make the incident public, pursue treatment and the legal system. Grace's mother was so forthcoming that one wondered whether abuse had actually occurred and whether perhaps the accusation was the result of Grace's need to fulfill her mother's needs. According to Klajner-Diamond et al. (1987), young children almost never initiate false allegations of sexual abuse. It is usually the adult, whether consciously or unconsciously, who is intent on proving to themselves or others that the allegations of abuse are true. Grace had been sexually abused by a stranger at age three but mother minimized its importance. It appears that Grace's abuse by her father could have reawakened in her mother feelings of rage about her own abuse by her own mother's live-in boyfriend at age six and her mother's failure to confront him. Her mother had failed her but she was not going to fail her daughter and perhaps even make up for her mother's passivity by being aggressive in her pursuits. Contrary to Vickie's mother, she seemed to overempathize with her daughter but only when the issues

reflected her own issues, namely abuse by a father figure.

The symptoms that Grace developed were hysteria, academic difficulties, hyperactivity, and aggression towards peers. She was provocative in a passive-aggressive manner, sexually seductive, clingy, and demanding. Her symptoms were much more typical of an externalization process. Grace presented herself as a very friendly youngster, contrary to Vickie who was quite reserved. She had strong dependency needs and very poor boundaries, and often regressed during sessions, wanting to be rocked and fed like a baby. She exhibited extreme forms of behavior from acting like a baby, helpless and dependent to wanting to play the mother, controlling and terribly disappointing. Interestingly enough, even when she played the role of mother, she was quick to protect that part of her, reassuring me, the baby, that mothers are supposed to act like that. Grace's mother, unfortunately had limited ability to identify with her daughter's struggles and pains and saw her daughter as having the same wishes and fantasies as her. For instance, she could not understand why Grace still maintained positive feelings towards her father. One will never know for sure, perhaps not even Grace, whether she was molested by her father but what is clear is the intensity of the symbiosis between Grace and her mother and Grace's willingness to sacrifice her selfhood by embarking in her mother's publicity of the event.

It is striking how the two mothers responded so differently to the sexual abuse disclosure of their daughters and the

symptoms the girls developed linked to their mothers' reactions. Vickie's mother failed to accept the abuse and Vickie in turn internalized much of her feelings and reactions. Grace, on the other hand, not only got support but even promotion of the experience and therefore she was able to express her distress in a more externalized manner.

Treatment Issues

Given the premise of this paper that mothers and daughters of sexual abuse often exhibit a narcissistic fusion in their pattern of relating, it is the therapeutic task to help the child and the mother to separate and ultimately for the mother to be able to empathize with the child in order to provide selfobject functions for the child. The therapist needs to work with the dyad in the articulation and integration of both the mother's and the child's affectivity in order for the child to ultimately regain and/or develop trust in this and other relationships.

In Vickie's case, therapy proved to be a challenge to the rigid external boundary that mother and daughter had created. Burkett (1991) believes that enmeshed families, typical of sexually abusive families, have fluid internal boundaries but overly strong external boundaries. Vickie held on tenaciously to her role of caretaker and confidant of her mother. Mother had great difficulty alleviating Vickie of this role as she relied solely on Vickie for affirmation, nurturance, and companionship. Vickie was typically intolerant of her own dependency needs and

she had great difficulty opening up and assuming a dependent position in therapy, often keeping me at a distance. While Vickie was totally merged in her role of caretaker, Grace was struggling with that position. Grace's mother often complained of Grace not being mature enough and Grace typically showed in her sessions the split between wanting to care and wanting to be cared for. In my role as therapist, I often felt put in the position of mothering both mother and daughter, while both competing for my attention and nurturance. For example, upon greeting me in the waiting room, Grace would run forward and drag me before I had a chance to talk to her mother. Grace had great difficulty leaving at the end of the session and if I met with her mother afterwards she would continuously bang on the door. Mother would become very angry and yell at her: "You had your time, now it's my time."

Treatment of sexually abused youngsters occurs at two levels. At one level, the attempt is to work through both the mother's and the daughter's internal representations of defective mirroring selfobjects. Through play therapy the children work at healing the disowned dependency needs - needs to be heard, empathized with, nurtured, and admired as separate and unique individuals on a continuous basis. The mothers engage in talk therapy, learning about, experiencing, and owning up to their own unmet needs as children, and needs to be mirrored and idealized, so that they can heal their own pain and in turn empathize with their children's wishes.

At another level, you treat the sexual abuse directly. *Massie & Johnson* (1989) and Root (1989) believe that if the sexual abuse is not addressed, treatment is likely to be unsuccessful. Dickstein et al. (1991) have identified five areas in which children need encouragement to express through play and/or talk the sexual trauma: 1) their guilt and shame; 2) positive and negative feelings towards the offender; 3) positive and negative feelings towards the nonoffending parent; 4) feelings about other family members' reactions; and 5) feelings about the reaction of the community at large. Both Vickie and Grace had a difficult time talking about the abuse. This is not surprising as their trust in adults had been shattered. The therapist needs then to be active in his/her interpretations or mirroring of the play, relating it to sexual abuse issues.

Often children will test their ability to trust the therapist and the inherent protection and safety of the therapeutic environment (Krieger et al., 1980). They may act out sexually or aggressively, they may act in a seductive manner, or ask for special favors or treatment. The key here is for the therapist to be firm and consistent in order not to repeat the seduction (Courtois, 1988; Krieger et al., 1980; Yates, 1987) and also to be non-judgmental in order for the child to be free to express her true feelings. The expression of anger is crucial to gain understanding of the abusive experience. Everstine and Everstine (1989) caution that the use of anger may also be used as a protection against other feelings, such as guilt as well as

sadness and grief at the loss of the idealized mother. The therapist needs to pay very close attention to his/her countertransference feelings in order not to overidentify with either the victim or the offender.

In terms of the mother's treatment, Dickstein et al. (1991) talk about the importance of realizing that mothers need immediate help in the period just after disclosure. They need help in dealing with the denial, their feelings and dealings with their child's sexual acting-out following abuse as well as their symptoms and regressive behaviors. Mothers may also need help in dealing with their own feelings of shame and guilt, as well as questionning their own judgment and reality testing about not having been able to provide adequate protection. Lipvosky (1991) believes that since these mothers were often abused themselves in childhood, issues relating to their experiences and the adaptation which they made to that abuse must be dealt with before such a mother is able to attend to the needs of her child.

Overall, the healing process of female sexual abuse is intricate in addressing and balancing the child and the mother's emotional needs. The therapist becomes an integral part of both the child's and the mother's self-experience and through the process of affect validation in a position of atunement the therapist helps them both sustain a sense of self-cohesion at a very traumatic point in their lives. In addition, the therapist offers to restore self fragmentations associated with a history of narcissistic disturbance.

REFERENCES

Adams-Tucker, C. (1982). Proximate effects of sexual abuse in childhood: A report on 28 children. American Journal of Psychiatry, 139, 1252-1256.

Brown, B. S. (1979). Clinical illustration of the sexual misuse of girls. Child Welfare, 17, 435-442.

Burkett, L. P. (1991). Parenting behaviors of women who were sexually abused as children in their families of origin. Family Process, 30, 421-434.

Courtois, C. A. (1979). The incest experience and its aftermath. Victimology, 4, 337-347.

Dickstein, L., Hinz, L. D., & Eth, S. (1991). Treatment of sexually abused children and adolescents. American Psychiatric Press Review of Psychiatry, 10, 345-366.

Dixon, K. N., Arnold, E., & Calestro, K. (1978). Father-son incest: Underreported psychiatric problem? American Journal of Psychiatry, 135, 835-838.

Everstine, D. S. & Everstine, L. (1989). Sexual Trauma in Children and Adolescents: Dynamics and Treatment. New York: Brunner Mazel.

Finklehor, D. (1979). Sexually Victimized Children. New York: Free Press.

Kaufman, I. (1954). The family constellation and overt incestuous relations between father and daughter. American Journal of Orthopsychiatry, 24, 266-277.

Klajner-Diamond, H., Wehrspann, W., & Steinhauer, P. (1987). Assessing the credibility of young children's allegations of sexual abuse. Canadian Journal of Psychiatry, 32, 610-614.

Kohut, H. (1971). The Analysis of the Self. New York: International Universities Press.

Kohut, H. (1977). The Restoration of the Self. New York: International Universities Press.

Krieger, M. J., Rosenfeld, A. A., G

Lewis, M. & Sarrel, P. M. (1969). Some psychological aspects of seduction, incest, and rape in childhood. Journal of the American Academy of Child Psychiatry, 8, 606-619.

Liebm, J. & Jacobs, N. (1990). Reassessing mother's blame in incest. Journal of Women in Culture and Society, 15, 500-615.

Lipovsky, J. A. (1991). Disclosure of father-child sexual abuse: Dilemmas for families and therapists. Contemporary Family Therapy, 13, 85-101.

Lustig, N. (1966). Incest: A family group survival pattern. Archives of General Psychiatry, 14, 31-40.

Massie, M. E. & Johnson, S. M. (1989). The importance of recognizing a history of sexual abuse in female adolescents. Journal of Adolescence Health Care, 10, 184-191.

McVicar, K. (1979). Psychotherapeutic issues in the treatment of sexually abused girls. Journal of Child Psychology and Psychiatry, 18, 342-353.

Miller, A. (1981). The Drama of the Gifted Child. New York: Basic Books.

Pelletier, G. & Handy, L. C. (1986). Family dysfunction and the psychological impact of child sexual abuse. Canadian Journal of Psychiatry, 31, 407-412.

Porter, F. S., Blick, L. C., & Sgroi, S. M. (1982). Treatment of the sexually abused child. In S. M. Sgroi (Ed.), Handbook of Clinical Intervention in Child Sexual Abuse. Toronto: Lexington.

Powell, G. E. & Chalkley, A. J. (1981). The effects of pedophile attention on the child. In B. Taylor (Ed.), Perspectives on Pedophilia. London: Batsford.

Root, M. P. (1989). Treatment failures: The role of sexual victimization in women's addictive behavior. American Journal of Orthopsychiatry, 59, 542-549.

Socarides, D. D. & Stolorow, R. D. (1986). Self psychology and psychoanalytic phenomenology. In: I. L. Kutash and A. Wolf (Eds.), Psychotherapist's Casebook (pp. 43-54). San Francisco: Jossey-Bass.

Tsai, M., Feldman-Summers, S., Edgar, M. (1979). Childhood molestation: Variables related to differential impacts on psychosexual functioning in adult women. Journal of Abnormal Psychology, 88, 407-417.

Wolf, V. V., Gentile, C. & Klink, A. (1988). Psychometric Properties of the Sexual Abuse Fear Evaluation (SAFE). Unpublished manuscript. University of Western Ontario. London, Ontario.